New Hampshire Medicaid Fee-for-Service Program
Hematopoietic Agent Criteria

Approval Date: June 10, 2024

Pharmacology

Erythropoietin is a glycoprotein that stimulates red blood cell production. It is produced in the kidney and stimulates the division and differentiation of committed erythroid progenitors in the bone marrow.

Indications

- Procrit, Epogen and Retacrit are indicated in the treatment of anemia of chronic renal failure, zidovudine-treated human immunodeficiency virus (HIV)-infected patients, anemia in cancer patients on chemotherapy, and reduction of allogeneic blood transfusions in surgery patients.
- Aranesp is indicated in the treatment of anemia associated with chronic renal failure, including patients on dialysis and not on dialysis, and for the treatment of anemia in patients with nonmyeloid malignancies where anemia is due to the effect of concomitantly administered chemotherapy.
- Mircera is indicated for the treatment of anemia associated with chronic kidney disease (CKD) in adult patients on dialysis and patients not on dialysis.

Medications

Brand Names	Generic Names	Dosage
Aranesp	darbepoetin alfa	**vial:** 25 mcg/mL, 40 mcg/mL, 60 mcg/mL, 100 mcg/mL, 200 mcg/mL **syringe:** 10 mcg/0.4 mL, 25 mcg/0.42 mL,40 mcg/0.4 mL, 60 mcg/0.3 mL, 100 mcg/0.5 mL, 150 mcg/ 0.3 mL, 200 mcg/0.4 mL, 300 mcg/0.6 mL, 500 mcg/1 mL
Epogen	epoetin alfa	2,000 U/mL, 3,000 U/mL, 4,000 U/mL, 10,000 U/mL, 20,000 U/mL, 20,000 U/2 mL
Procrit	epoetin alfa	2,000 U/mL, 3,000 U/mL, 4,000 U/mL, 10,000 U/mL, 20,000 U/mL, 20,000 U/2 mL, 40,000 U/mL
Mircera	methoxy polyethylene glycol-epoetin beta	30 mcg/0.3 mL, 50 mcg/0.3 mL, 75 mcg/0.3 mL, 100 mcg/0.3 mL, 150 mcg/0.3 mL, 200 mcg/0.3 mL
Retacrit	epoetin alfa-epbx	2,000 U/ mL, 3,000 U/ mL, 4,000 U/ mL, 10,000 U/ mL, 20,000 U/ mL, 20,000 U/2 mL, 40,000 U/mL

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Criteria for Approval

1. A documented HCT less than 30%; **AND**
2. A documented hemoglobin (Hb) less than10 g/dL; **AND**
3. Iron levels performed (transferrin saturation 20% or more, ferritin 100 ng/mL or more); **AND**
4. Lab data within two months of prior authorization (PA) submission; **AND**
5. One of the following diagnoses:
   - Anemia associated with chronic kidney disease, predialysis, or on dialysis (this is the only diagnosis that can be approved for Mircera); **OR**
   - Anemia associated with cancer chemotherapy; **OR**
   - Anemia in cancer patients who are not treated with chemotherapy but have anemia associated with any of the following: prior chemotherapy, prior radiation therapy, current treatment with radiation therapy, or malignancy; **OR**
   - Anemia in patients with HIV who are receiving zidovudine therapy (Procrit, Epogen, or Retacrit only); **OR**
   - Reduction of allogeneic blood transfusions in surgery patients (Procrit, Epogen, or Retacrit only); **OR**
   - Anemia in myelodysplastic syndromes (MDS); **OR**
   - Anemia in lymphoproliferative disease; **OR**
   - Anemia due to ribavirin use in patients infected with hepatitis C.

Length of Approval: 6 months

Criteria for Denial

1. Criteria for approval not met; **OR**
2. A documented HCT > 36%; **AND**
3. A documented Hb > 12 g/dL; **OR**
4. One of the following diagnoses:
   - Pruritis (uremic); **OR**
   - Patients requiring immediate correction of severe anemia; **OR**
   - Anemia in patients with rheumatoid arthritis; **OR**
   - Anemia of prematurity; **OR**
   - Anemia in women with postpartum iron deficiency anemia; **OR**
   - Sickle-cell anemia in patients who do not respond to hydroxyurea; **OR**
   - Patients with cancer receiving hormonal agents, biologic products, or radiotherapy, unless also receiving concomitant myelosuppressive chemotherapy or in whom anemia can be managed by transfusion (Procrit, Epogen, Aranesp or Retacrit only); **OR**
   - Anemia due to cancer chemotherapy (Mircera only).

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Criteria for Denial of a Renewal

1. Appropriate dose increase did not produce more than 1 g/dL in Hb; **OR**
2. A documented HCT more than 36%; **AND**
3. A documented Hb more than 2 g/dL.

References

Available upon request.

Revision History

Reviewed by	Reason for Review	Date Approved
Pharmacy & Therapeutic Committee	New	11/02/2006
Commissioner	New	11/16/2006
Pharmacy & Therapeutic Committee	Revision	06/19/2008
Commissioner	Approval	07/22/2008
DUR Board	Revision	10/25/2010
Commissioner	Approval	02/10/2011
DUR Board	Revision	05/31/2016
Commissioner	Approval	06/18/2016
DUR Board	Revision	09/27/2018
Commissioner Designee	Approval	11/27/2018
DUR Board	Revision	03/12/2019
Commissioner Designee	Approval	04/05/2019
DUR Board	Revision	06/30/2020
Commissioner Designee	Approval	08/07/2020
DUR Board	Revision	06/08/2021
Commissioner Designee	Approval	08/13/2021
DUR Board	Revision	12/13/2022
Commissioner Designee	Approval	01/26/2023
DUR Board	Revision	05/07/2024
Commissioner Designee	Approval	06/10/2024

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